

FY18 Annual Enrollment Factsheet

Name _____			
Address _____	City _____	State _____	Zip Code _____
Social Security Number _____		Birth Date _____	Gender _____
Date of Hire _____			

As a new employee, one of the first things you'll want to do is select benefits for yourself and your eligible spouse and dependent(s). Before you enroll, read through the enrollment material at <http://benefits.sd.gov> for more detailed information about benefit choices and plan features. Mark your FY18 elections on this Factsheet to use as a guide when enrolling online.

If you do not make benefit elections within 30 days of hire:

- You will be given the default coverage (High Deductible Health Plan), with no spouse or dependent coverage.
- You will not be eligible for Flexible Benefits until Annual Enrollment.
- You will not be able to make benefit elections for yourself and/or any eligible spouse or dependent(s) without a qualified family status change (i.e. birth, pending birth, adoption, marriage, etc) or until the next Annual Enrollment.

To enroll visit <http://benefits.sd.gov> (NEW HIRES ONLY)

- Click on **Active Employee**
- Click on **New Employees**
- Click on **Click Here to Enroll**
- Click on the **Register** button
- Enter an email address, username, and password. Re-enter the password.
- Click the check box next to the text, "I'm not a robot." (A popup of image tiles will appear. Follow the instructions in the popup.)
- Click the **Register** button
- An email will be sent to the address you entered
- Open the confirmation email sent to your account and click the link it contains
- You will be redirected to the Log in screen
- Log in by entering the user name and password you provided early
- Click the check box next to the text, "I'm not a robot." (A popup of image tiles will appear. Follow the instructions in the popup.)
- Click the **Log in** button

Eligible Spouse and Dependent Information

You must provide the following information about any eligible spouse or dependents you wish to enroll. To make the process easier, write that information below and refer to it during your enrollment. List only a spouse and/or dependents you want to cover in FY18. The plans to the far right of the sheet indicate benefit choices you can make for your spouse and each dependent. Please note: The relationship codes are self, spouse, and child.

Name	SSN	Birthday	Gender	Relationship	Health/Dental/Vision/Accident/HIP
				Self	

Refer to your Summary Plan Description Document for details about eligible spouse and dependents, initial and special enrollment periods, and definition of late entrants.

Health Plan

Plan Options:

- ☐ Opt-Out* (no coverage)
- ☐ Low Deductible Health Plan (\$850)
- ☐ High Deductible Health Plan (\$1,800|\$3,600) with Health Savings Account (HSA)

Coverage Levels: (visit <http://benefits.sd.gov> for contribution rates)

- ☐ Employee only
- ☐ Employee + one child
- ☐ Employee + two children
- ☐ Employee + three or more children
- ☐ Employee + spouse
- ☐ Employee + spouse + one child
- ☐ Employee + spouse + two or more children

*If you elect to Opt-Out of the Health Plan, you must provide proof of credible coverage from another group health plan by providing satisfactory written evidence to the Bureau of Human Resources. You are also eligible to receive an Opt Out credit of \$300. Please refer to the Summary Plan Description Document at <http://benefits.sd.gov> for more information.

Tobacco User Status

- ☐ Neither my covered spouse nor I use a tobacco product
- ☐ Only I use a tobacco product
- ☐ Only my covered spouse uses a tobacco product
- ☐ My covered spouse and I both use a tobacco product

Coordination of Benefits

Are you (the employee) covered for health care coverage under another group health plan or Medicare?

- ☐ Yes
☐ No

If your spouse or any of your dependents are covered under the South Dakota State Employee Health Plan, are they also covered for health care coverage under another group health plan?

- ☐ Yes
☐ No

Dental Plan

Base Plan Coverage Levels:

- ☐ No coverage
☐ Employee only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Premiums Per Pay Period	
24 Pay Periods	12 Pay Periods
\$ 0.00	\$ 0.00
\$ 16.20	\$ 32.40
\$ 32.35	\$ 64.70
\$ 35.41	\$ 70.82
\$ 51.56	\$ 103.12

Enhanced Plan Coverage Levels:

- ☐ No coverage
☐ Employee only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Premiums Per Pay Period	
24 Pay Periods	12 Pay Periods
\$ 0.00	\$ 0.00
\$ 26.17	\$ 52.34
\$ 52.25	\$ 104.50
\$ 53.28	\$ 106.56
\$ 79.37	\$ 158.74

Vision Plan

Coverage Levels:

- ☐ No coverage
☐ Employee only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Premiums Per Pay Period	
24 Pay Periods	12 Pay Periods
\$ 0.00	\$ 0.00
\$ 3.33	\$ 6.66
\$ 6.67	\$ 13.34
\$ 5.65	\$ 11.30
\$ 9.31	\$ 18.62

Accident Insurance Plan

Coverage Levels:

- ☐ No coverage
☐ Employee only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Premiums Per Pay Period	
24 Pay Periods	12 Pay Periods
\$ 0.00	\$ 0.00
\$ 4.03	\$ 8.06
\$ 6.10	\$ 12.20
\$ 7.99	\$ 15.98
\$ 10.22	\$ 20.44

Hospital Indemnity Plan (HIP)

Coverage Levels:

- ☐ No coverage
- ☐ Employee only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

Premiums Per Pay Period	
24 Pay Periods	12 Pay Periods
\$ 0.00	\$ 0.00
\$ 4.36	\$ 8.72
\$ 5.81	\$ 11.62
\$ 8.92	\$ 17.84
\$ 11.81	\$ 23.62

Short-Term Disability Income Protection Plan

Coverage Level:

- ☐ No coverage
- ☐ Employee only

Premiums Per Pay Period	
24 Pay Periods	12 Pay Periods
\$ 0.00	\$ 0.00
\$ 3.98	\$ 7.96

Health Savings Account (only with High Deductible Health Plan)

The annual maximum contribution to a Health Savings Account is \$3,400 for individual and \$6,750 for a family for 2017 calendar year (this includes both the State's contribution plus any contributions you choose to make). The amount you enter below is per pay period.

Options:

- ☐ I am not eligible
- ☐ I prefer not to have an HSA
- ☐ Participating with no payroll contributions
- ☐ I want an HSA and will contribute the following amount each pay period \$ _____.

Medical Flexible Spending Account

The annual maximum deposit to the Medical Flexible Spending Account is \$2,600 for 2017 calendar year. The amount you enter below is per pay period.

Options:

- ☐ No participation
- ☐ Participate and contribute \$ _____ per pay period

Dependent Care/Day Care Flexible Account Spending

Based on your tax filing status, the maximum you can contribute annually is \$5,000 per household. See your Summary Plan Description Document for rules that may affect contribution amounts. The amount you enter below is per pay period.

Options:

- ☐ No participation
- ☐ Participate and contribute \$ _____ per pay period

Enter your CONFIRMATION NUMBER for your records _____

Life Enrollment

The South Dakota State Employee Health Plan provides you with Basic Life Coverage through VOYA Financial in the amount of \$25,000. You may also elect additional Supplemental Life Coverage and Dependent Life Coverage, which you are able to continue when you leave state employment.

Employee Supplemental Life Insurance

Options:

- ☐ No coverage
- ☐ 1 x annual salary
- ☐ 2 x annual salary
- ☐ 3 x annual salary
- ☐ 4 x annual salary
- ☐ 5 x annual salary

You may choose Supplemental Life Coverage equal to one, two, three, four, or five times annual salary (rounded to the next highest multiple of \$1,000 but in no event shall the amount of coverage exceed \$400,000). The cost for this coverage depends on the amount of coverage you choose and your age.

If you elect Supplemental Life coverage, you will receive a Basic Long Term Care monthly facility benefit of \$1,500 per month coverage with a two year duration through Unum.

See your Summary Plan Description Document for more information about Long Term Care.

PREMIUM RATE PER \$1000 OF COVERAGE PER PAY PERIOD

<u>AGE GROUP</u>	<u>24 Pay Periods</u>	<u>12 Pay Periods</u>
<25	\$0.040	\$0.08
25 to 29	\$0.040	\$0.08
30 to 34	\$0.050	\$0.10
35 to 39	\$0.060	\$0.12
40 to 44	\$0.070	\$0.14
45 to 49	\$0.095	\$0.19
50 to 54	\$0.135	\$0.27
55 to 59	\$0.205	\$0.41
60 to 64	\$0.300	\$0.60
65 to 69	\$0.560	\$1.12
70+	\$0.905	\$1.81

Employee Accidental Death & Dismemberment (AD&D)

The AD&D coverage provides an additional benefit in the case of accidental death and dismemberment. AD&D must equal the Supplemental Life Coverage.

Options:

- ☐ Yes, I want AD&D.
- ☐ No, I don't want AD&D.
- ☐ N/A

PREMIUMS PER \$1000 OF COVERAGE PER PAY PERIOD

24 Pay Periods	12 Pay Periods
\$0.015	\$0.03

Dependent Life Insurance

Employees who are covered under Supplemental Life coverage may elect \$10,000 Dependent Life Coverage. The cost is the same regardless of the number of eligible dependents. If Employee AD&D is elected, it will also apply to Dependent Life Coverage. The contribution rate for 24 pay periods is \$0.15 and for 12 pay periods \$0.30.

Options:	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
<input type="checkbox"/> No coverage	\$ 0.00	\$ 0.00
<input type="checkbox"/> \$10,000 Life coverage	\$ 1.13	\$ 2.26
<input type="checkbox"/> \$10,000 AD&D coverage	\$ 0.15	\$ 0.30

Life Insurance Beneficiary(ies)

Enter the beneficiary(ies) first name, last name, address, relationship (i.e. spouse, child or other), and share to each beneficiary.

Primary Beneficiary(ies)

First Name/Last Name	Address	Relationship	Share to each

Contingent Beneficiary(ies)

First Name/Last Name	Address	Relationship	Share to each